From Sen. Caswell

SB 422 (S-1) changes

MAGI
Page 2, lines 12-17: Clarified that determining household income would be done using MAGI

Definition of Resident:
Page 3, line 27 and page 4, lines 1-5: Changed the definition of "Resident" to require an individual to be a citizen of the United States or somebody legally present in the United States and who has lived in Michigan for more than 6 months.

Expending Funds
Page 4, lines 16-20: Clarified that the director shall expend money from the fund to administer the act and, if additional money is available, to provide additional benefits for members. Adds further clarifying language stating making it clear that one potential use of additional funds would be increasing the cap on inpatient hospitalization coverage.

Health Care Professionals
Page 5, lines 3-8: Clarified that the director shall ensure that any health care professional who participates with a Medicaid contracted health plan will accept patients enrolled in this state health plan.

Federally Qualified Health Centers
Page 6, lines 2-4: Clarified that if a FQHC accepts patients from the state run health plan the rates paid for those patients will be no more than the Medicaid rates paid in FY 2011-12.

Copays
Page 6, lines 9-12: Requires the director to establish a copay that is the same as the amount required under Medicaid

Primary Care and Preventative Services
Page 6, lines 19-22: Clarifies that primary care and preventative services will be paid at the Medicaid rates in place in FY 2011-12

Generic/Name Brand Drugs
Page 6, lines 23-27, page 7, lines 1-2: Requires the use of a generic drug when such an alternative exists" (Kandler language) and references back to the George/Hammerstrom legislation for determining use of name brand psychotic/psychotropic drugs.

Inpatient Hospitalization
Page 7, lines 5-12: Clarifies that inpatient hospitalization procedures will be paid at the Medicaid rates in place in FY 2011-12 and further clarifies that the annual inpatient hospitalization cap for an individual is $35,000. Also adds language clarifying that if there is additional money in the fund the DCH Director may use that additional money to increase the $35,000 cap.

Specialty Prepaid Health Plan
Page 7, lines 16-19: Replaced the phrase "prepaid inpatient health plan" which is a federal term not used in Michigan with "Specialty Prepaid Health Plan"

Plan Ineligibility
Page 8, lines 3-13: Clearly states that an individual who does not pay the required contributions will be ineligible for 3 months (consistent with MI Child) before they can be added back to the plan. It also adds language requiring any previous unpaid contribution to be paid back before a person can be readmitted to the plan.

Sunset:
Page 9, line 6 – Added Section 19 which sunsets this act on January 1, 2017